Senate

General Assembly

File No. 227

January Session, 2011

Senate Bill No. 1084

Senate, March 28, 2011

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

AN ACT CONCERNING OUT-OF-POCKET EXPENSES FOR NONPREFERRED BRAND NAME DRUGS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective January 1, 2012*) No insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity that delivers, issues for delivery, renews, amends or continues in this state an individual health insurance policy that provides coverage for prescription drugs shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for nonpreferred brand name drugs that places a greater financial burden on an insured than for preferred brand name drugs.

Sec. 2. (NEW) (*Effective January 1, 2012*) No insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity that delivers, issues for delivery, renews, amends or continues in this state a group health insurance policy that provides coverage for prescription drugs shall impose a

coinsurance, copayment, deductible or other out-of-pocket expense for nonpreferred brand name drugs that places a greater financial burden on an insured than for preferred brand name drugs.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2012*	New section
Sec. 2	*January 1, 2012*	New section

INS *Joint Favorable*

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 12 $	FY 13 $
Comptroller Misc. Accounts (Fringe Benefits)	GF & TF - Cost	No less than $2,381,423	No less than $4,762,845

Note: GF=General Fund and TF = Transportation Fund

Municipal Impact:

Municipalities	Effect	FY 12 $	FY 13 $
Various Municipalities	STATE MANDATE - Cost	Potential Significant	Potential Significant

Explanation

As of July 1, 2008, the State Employees' Prescription Plan went self insured. Pursuant to current federal law, the state's self-insured plan would be exempt from state health insurance benefit mandates. However, in previous self-funded arrangements the state has traditionally adopted all state mandates.

In addition, all employee and retiree health plans are provided in accordance with the collective bargaining agreement negotiated between the State and the State Employee Bargaining Agent Coalition (SEBAC). CGS Sec. 5-278 (f) recognizes SEBAC to negotiate with the State on retirement and health benefits. In 1997 the State and SEBAC negotiated a long-term health and retirement benefit agreement, which is effective through 2017. This agreement was most recently modified in 2009. Therefore, any plan changes required to carry out the bill and implement the mandate would require collective bargaining agreement.

To the extent that the state continues this practice of voluntary

mandate adoption and SEBAC agrees to the modifications required by the bill, the following impact would be anticipated.

The bill's provisions would increase costs to the State Employee Prescription Plan by approximately no less than $2,381,423 in FY 12 and $4,762,845 in FY 13. Costs would not accrue to the state plan until January 1, 2012; therefore, FY 12 costs reflect a partial year cost. The cost is a result of three factors: 1) transitioning the state plan from a three tier plan to a two tier plan, 2) higher utilization of non-preferred and more costly brand name drugs, and 3) a reduction in prescription rebates the state is currently eligible for with a three tier prescription plan. Currently, the state's three-tier prescription drug plan requires a $5 co-pay for generic drugs, $10 for preferred drugs, and $25 for non-preferred drugs. Eliminating the co-pay differential makes up approximately 40% of the total estimated cost of the bill ($956,423 in FY 12 and $1,912,845 in FY 13).

The bill's provisions may increase costs to certain fully insured municipal plans which require higher copayments for non-preferred prescriptions. The increased cost to municipalities would depend on: 1) the difference between non-preferred and preferred brand name drug co-pays, 2) utilization shift from preferred drug use to non-preferred drug use, and 3) any impact on rebates the changes might have. The coverage requirements may result in increased premium costs when municipalities enter into new health insurance contracts after January 1, 2012. Due to federal law, municipalities with self-insured health plans are exempt from state health insurance benefit mandates.

The state employee health plan and many municipal health plans are recognized as "grandfathered" health plans under the Patient Protection and Affordability Care Act (PPACA). It is unclear what effect the adoption of certain health mandates will have on the grandfathered status of the state employee health plan or

grandfathered municipal plans PPACA[1].

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation. It is unclear what effect a two tier structure would have on the state or municipalities ability to secure favorable pricing and prescription drug rebates in the out-years.

The federal health care reform act requires that, effective January 1, 2014; all states must establish a health benefit exchange, which will offer qualified plans that must include a federally defined essential benefits package. While states are allowed to mandate benefits in excess of the basic package, the federal law appears to require the state to pay the cost of any such additional mandated benefits. The extent of these costs will depend on the mandates included in the federal essential benefit package, which have not yet been determined. However, neither the agency nor mechanism for the state to pay these costs has been established.

[1] According to the PPACA, compared to the plans' policies as of March 23, 2010, grandfathered plans who make any of the following changes within a certain margin may lose their grandfathered status: 1) Significantly cut or reduce benefits, 2) Raise co-insurance charges, 3) Significantly raise co-payment charges, 4) Significantly raise deductibles, 5) Significantly lower employer contributions, and 5) Add or tighten annual limits on what insurer pays. (www. healthcare. gov)

OLR Bill Analysis

SB 1084

AN ACT CONCERNING OUT-OF-POCKET EXPENSES FOR NONPREFERRED BRAND NAME DRUGS.

SUMMARY:

This bill prohibits certain individual and group health insurance policies that provide prescription drug benefits from imposing a coinsurance, copayment, deductible, or other out-of-pocket expense for nonpreferred brand named drugs that place a greater financial burden on an insured than for preferred brand name drugs.

The bill applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut by an insurer, fraternal benefit society, hospital or medical service corporation, HMO, or other entity.

Due to the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: January 1, 2012

BACKGROUND

Related Bills

SB 13 (File 10), reported favorably by the Insurance and Real Estate Committee, prohibits certain health insurance policies and medical contracts from imposing payment provisions or conditions (e.g., copayment, reimbursement amount, number of doses) for prescriptions obtained from a retail pharmacy that are more restrictive than those imposed for prescriptions obtained from a mail order pharmacy.

SB 153 (File 123), reported favorably by the Insurance and Real Estate Committee, allows an insured to obtain a prescription drug refill up to two business days before the date it is authorized to be refilled.

SB 1083, reported favorably by the Insurance and Real Estate Committee, prohibits certain individual and group health policies that provide prescription drug coverage from requiring an insured to use an alternative brand name prescription drug or over-the-counter drug before using a brand name prescription drug prescribed by a licensed physician for pain treatment.

HB 5439, reported favorably by the Insurance and Real Estate Committee, establishes a task force to study prescription drug coverage insurance plans available to state residents.

HB 6349 (File 102), prohibits certain health insurers that provide prescription drug coverage from denying coverage for the refilling of any drug prescribed to treat a chronic illness if the refill is made in accordance with a plan to synchronize the refilling of multiple prescriptions.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable
Yea 11 Nay 9 (03/15/2011)